Kansas Medical Assistance Program
Drug Utilization Review Bulletin

July 2006

Prescription Drug Abuse
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Prescription drug abuse is a complicated problem. Physicians are faced with the challenge of providing treatment when indicated and preventing diversion or misuse of prescription drugs.[1,2] Abuse and addiction need to be differentiated from dependence. Abuse is excessive use of a drug or use of a drug for purposes for which it was not medically intended. Addiction is chronic substance abuse. It is a relapsing disease characterized by compulsive drug seeking and use, craving and continued use despite harm. Addiction is not the same as dependence. One can become dependent on a drug--tolerant to its effects and suffer withdrawal when use is discontinued--without becoming addicted. The challenge is meeting the balance where treatment is provided when indicated and preventing diversion or misuse of prescription drugs.[2,3]

The controlled prescription drugs most often implicated with abuse fall within the following classes: opiate analgesics, CNS stimulants and CNS depressants. Most controlled prescription drug abusers are poly-substance abusers: 74.7% who also abuse alcohol and/or illicit drugs; 63.9% also abuse alcohol and 53.6% also abuse illicit drugs. About 25% abuse only prescription drugs[4]

New abusers of controlled prescription drugs are growing at an even more alarming rate with teens especially at risk. The number of teens abusing these drugs for the first time grew by 542% from 1992 to 2002. This is four times the rate of increase among those ages 18 and over. And the number of teens abusing steroids increased 126 percent from 1991 to 2003 with the rate of increase five times greater for girls than for boys.[4]

Access and Accountability
Access to controlled prescription drugs is apparently not too difficult either according to a 2004 survey from the National Center on Addiction and Substance Abuse (CASA) at Columbia University. This survey indicates that only about half (53.8%) of physicians ask about prescription drug abuse when taking a patient's health history and only about half (54.5%) either always or most of the time call or obtain records from the patient's previous (or other treating) physician before prescribing controlled drugs on a long-term basis.[4]

The CASA survey also found a significant proportion of pharmacists accountable for easy access. Approximately 28% of the pharmacists surveyed do not regularly validate the prescribing physician's DEA number when dispensing controlled drugs. Others admit to dispensing a controlled drug without a written prescription order (but in response to a phone order) or based on a prescription order that is missing information.[4]

Steps recommended by CASA that may help prevent controlled prescription drug diversion and abuse include the following:

- contacting a patient's prior physician to identify those with an abuse/diversion history;
- medication contracts to help ensure adherence to a prescribed regimen;
- drug testing to monitor whether a patient has taken a prescribed drug;
- pill counts to ensure that the patient has not used (or diverted) more than the indicated amount of a drug;
- prescribing limited doses of the drug at a time; and
- educating patients about the dangers of controlled prescription drug abuse.

CASA's survey of physicians found that when suspecting a patient of diversion or abuse, about 28% usually require urine tests, 23% usually conduct pill counts and about 37% usually create a medication contract.[4]

Most pharmacists and physicians believe patients account for the majority of the drug diversion problem. Methods of diversion include providing fraudulent prescriptions, impersonating physicians, altering prescriptions, pressuring or deceiving physicians, dentists, nurses or veterinarians and doctor shopping.[4] Prescription drugs can also be diverted from any point within the manufacturing process through distribution to pharmacy, clinics and hospitals.

Recognizing the Drug Abuser[3]

Differentiating the legitimate patient from a drug abuser is a challenge. The following tables include strategies provided by the DEA. Recognizing these characteristics is a method for identification of drug seeking individuals.[3]

Common Characteristics of the Drug Abuser

- Unusual behavior in the waiting room;
- Assertive personality, often demanding immediate action;
- Unusual appearance - extremes of either slovenliness or being over-dressed;
- May show unusual knowledge of controlled substances and/or gives medical history with textbook symptoms OR gives evasive or vague answers to questions regarding medical history;
- Reluctant or unwilling to provide reference information. Usually has no regular doctor and often no health insurance;
- Will often request a specific controlled drug and is reluctant to try a different drug;
- Generally has no interest in diagnosis - fails to keep appointments for further diagnostic tests or refuses to see another practitioner for consultation;
- May exaggerate medical problems and/or simulate symptoms;
- May exhibit mood disturbances, suicidal thoughts, lack of impulse control, thought disorders, and/or sexual dysfunction;
- Cutaneous signs of drug abuse - skin tracks and related scars on the neck, axilla, forearm, wrist, foot and ankle. Such marks are usually multiple, hyper-pigmented and linear. New lesions may be inflamed. Shows signs of "pop" scars from subcutaneous injections.

Deceptions that May be Used by Drug Abusers or Diverters

- Must be seen right away;
- Wants an appointment toward end of office hours;
- Calls or comes in after regular hours;
- States he/she's traveling through town, visiting friends or relatives (not a permanent resident);
- Feigns physical problems, such as abdominal or back pain, kidney stone, or migraine headache in an effort to obtain narcotic drugs;
- Feigns psychological problems, such as anxiety, insomnia, fatigue or depression in an effort to obtain stimulants or depressants;
- States that specific non-narcotic analgesics do not work or that he/she is allergic to them;
- Contends to be a patient of a practitioner who is currently unavailable or will not give the name of a primary or reference physician;
- States that a prescription has been lost or stolen and needs replacing;
- Deceives the practitioner, such as by requesting refills more often than originally prescribed;
- Pressures the practitioner by eliciting sympathy or guilt or by direct threats;
- Use a child or an elderly person when seeking methylphenidate or pain medication.

Medicaid has systems in place to help monitor or identify cases of diversion or abuse. Patients who are suspected of diverting or abusing drugs can be locked into one prescriber or pharmacy. A program like this may help to control costs and diversion by preventing doctor shopping (e.g., obtaining controlled substances from multiple prescribers).[4]

The following tables provide data specific to Kansas Medical Assistance Program (KMAP). The first table provides claims activity during the first quarter of 2006 within the drug classes commonly associated with drug abuse.

Drugs Commonly Implicated with Abuse: Claims Activity, January - March 2006				
Drug Class	**Claims**	**Paid**	**% Program Claims**	**% Program Paid**
Narcotic Analgesics	44,958	$1,600,536	6.1%	3.7%
Benzos, Antianxiety*	18,529	$188,021	2.5%	0.4%
Methylphenidate	11,446	$825,052	1.6%	1.9%
Amphetamines	9,881	$683,089	1.3%	1.6%
NonBenzo, Sedative/hypnotic	4,246	$342,206	0.6%	0.8%
Barbiturates	2,188	$11,507	<0.1%	<0.1%
Dexmethylphenidate	1,741	$126,007	0.2%	0.3%
Benzos, Sedative/hypnotic	1,477	$14,868	0.2%	<0.1%
Carisoprodol**	505	$7,088	0.1%	<0.1%
Androgenic Steroids	150	$39,249	<0.1%	0.1%
Totals	**95,121**	**$3,837,623**	**13%**	**8.8%**
Total Program Paid: $43,637,178				
Total Progam Claims: 734,467				

*includes diazepam. ** meprobamate is the active metabolite of carisoprodol (Soma®)

The following tables provide results from a recent evaluation of the KMAP population in an attempt to identify potential misuse of drugs of abuse. Further review of individual patient profiles would be necessary to identify potential misuse issues. The Quality Assurance Team and the Drug Utilization Review Board complete these reviews and will notify the provider through mailings when necessary.

Opiates	**# of Patients**
Doctor Shopper: Opiates w/o Cancer	7
Multiple Prescribers: Opiates w/o Cancer	407
Overutilization: Opiates w/o Cancer	81
Total	**495**

Carisoprodol	**# of Patients**
Overuse carisoprodol	28
Overuse carisoprodol in conjunction with benzodiazepines or opiates	122
Total	**150**

Benzodiazepines	**# of Patients**
Doctor shopper: benzodiazepines	10
Multiple prescribers w/potential overuse: benzodiazepines	80
Total	**90**

Stimulants	**# of Patients**
Doctor shopper: stimulants	18
Multiple prescribers: stimulants	192
Overutilization: stimulants	42
Stimulant use and h/o dependence	121
Total	**373**

Within the opiates, patients with a history of cancer were excluded if they had a documented history of malignant cancer via ICD-9 codes in all available claims data or an inferred history via the presence of an antineoplastic claim during the last 180 days. Doctor shopper was considered as claims attributed to 3 or more prescribers AND 3 or more pharmacies within a 60 day time frame. Multiple prescribers used the same criteria, but less than 3 pharmacies were involved. Opiate overutilization was considered as 8 or more claims for at least 2 different opiates with 150 or more days supply (collectively) in the last 60 days. Carisoprodol overutilization was considered as 3 or more claims of carisoprodol within the last 60 days. Benzodiazepine overutilization was considered as 3 or more claims attributed to 3 or more prescribers and having 60 or more days supply (collective) in the last 60 days Stimulant overutilization was considered as 6 or more claims for at least 2 different stimulants with 120 or more days supply (collectively) in the last 60 days.

Conclusion

Prescription drug abuse has a long standing history. It is a serious and growing problem affecting all age groups. Diversion of prescription drugs has many sources and the prescriber or pharmacy may not be the sole source. Differentiating the legitimate patient from the abuser presents a challenge to the physician and pharmacist as well. Achieving this balance should be a joint effort among the healthcare profession, regulatory agencies, health insurance providers and the general public.

If you would like to report a Kansas Medicaid patient you suspect of possible abuse or diversion of prescription drugs, please contact the fiscal agent at 1-800-933-6593 (in-state providers) or (785) 274-5990, option 0, between 7:30 a.m. and 5:30 p.m., Monday through Friday. Concerns will be carefully evaluated and directed to the appropriate staff for research, follow-up, and action if needed. You will be notified of the outcome.

References

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2. United States Government Accountability Office. Report to Congressional Requestors. Prescription Drugs. Oxycontin Abuse and Efforts to Address the Problem. December 2003.
3. Drug Enforcement Agency. Don't be scammed by a drug abuser. Available at http://www.deadiversion.usdoj.gov/pubs/brochures/index.html (accessed 6/9/06).
4. The National Center on Addiction and Substance Abuse at Columbia University. Under the Counter: The Diversion and Abuse of Controlled Prescription Drugs in the U.S. July 2005.